7. Absences

Non-Emergency Medically Necessary Transportation (NEMNT) and Adult Care Home Personal Care (ACH/PC) are covered by Medicaid when the resident is currently admitted to the adult care home. This section provides guidance on what you must do if the resident dies, is discharged, or later re-admitted, as well as how to handle a temporary absence such as therapeutic leave.

7.1 Death

If a resident dies at the adult care home, you must report the death to the county department of social services according to the rules by which the adult care home is licensed. If the resident received case management services, you must notify the resident's case manager as well. Transportation and ACH/PC are covered on the date of death if the resident died at the adult care home. The date of death is a covered date of service if the resident was on therapeutic leave at the time of death.

7.2 Discharge

If a resident is discharged from the adult care home, you must notify the county department of social services according to the rules by which the adult care home is licensed. If the resident was receiving case management services, you must notify the resident's case manager. Transportation and ACH/PC are not covered on the date of discharge from the adult care home. The date of discharge is not a covered date of service if the resident was on therapeutic leave at the time of discharge.

7.3 Re-admissions

How you should handle a re-admission after a discharge depends on where the individual resided during the absence.

7.3.1 Re-admitted from Home or Another Adult Care Home

When a former resident is re-admitted from a private home or another adult care home (one with a different Medicaid provider), you must treat this individual as a new admission and conduct a new assessment, prepare a new ACH/PC care plan, and obtain a new physician authorization for the service as outlined in Section 4 of this manual. This process starts a new annual reassessment cycle for ACH/PC for the home.

7.3.2 Re-admitted from Hospital, Nursing Facility, or ICF-MR

When an individual is being re-admitted to the adult care home after being discharged from that same home to a hospital, nursing facility, or ICF-MR, you must confirm that adult care home level of care continues to be appropriate for the resident according to the rules by which the home is licensed, and ACH/PC is still appropriate for meeting the resident's needs. You may resume providing ACH/PC for the re-admitted resident by one of the following two processes:

- **Re-admitted with Existing Care Plan**

  You may resume ACH/PC for a re-admitted resident by documenting that the existing care plan continues to be appropriate for meeting the resident's needs. If you do not conduct a formal reassessment and no changes are made in the existing care plan, your current annual reassessment cycle for ACH/PC continues as scheduled.

- **Re-admitted with a New Assessment and Care Plan**

  You may also consider a re-admitted resident as a new admission by conducting a new assessment, preparing a new ACH/PC care plan, and obtaining a new physician authorization for the service as outlined in Section 4 of this manual. This starts a new annual reassessment cycle for ACH/PC.

7.4 Therapeutic Leave

Therapeutic leave is a part of Medicaid's coverage of ACH/PC. The purpose of therapeutic leave is to allow the resident time away from the adult care home to be with family members or significant others, while reserving the resident's bed in the home. Therapeutic leave may not be taken for purposes of receiving inpatient or nursing services, provided either elsewhere or at a different level of care in the facility of residence, when such services are or will be paid for by Medicaid. Medicaid will reimburse adult care homes and nursing facilities for a total of 60 days of physician-ordered therapeutic leave in a calendar year for each Medicaid recipient.

Therapeutic leave must be ordered by the resident's physician. Documentation of the physician's orders for therapeutic leave must be in the resident's records. If the resident takes therapeutic leave often, ask the resident's physician to give you "standing orders" for the resident to take therapeutic leave as needed. The physician may give you standing orders for therapeutic leave by checking the appropriate block in the physician's authorization statement on the DMA-3050. Because therapeutic leave involves a temporary change in the resident's care, do not schedule therapeutic leave days in the care plan.

Document each period of therapeutic leave in the resident's records. Keep a record of the date and time the resident, or resident's representative, signs the resident out from and back into the adult care home. If more than 15 consecutive therapeutic leave days are needed by the resident, request prior approval from EDS. The address and telephone number for EDS' Prior Approval Unit is in Appendix B.

Note: A resident may take therapeutic leave days away from the adult care home as desired and according to the rules by which the home is licensed. You may not limit a resident to taking only therapeutic leave days that are covered by and billable to Medicaid. You may not bill for ACH/PC payments for days that the resident is on therapeutic leave. While the resident is on therapeutic leave, you must reserve the resident's bed and may not derive any Medicaid revenue for the bed besides that paid to the facility by Medicaid for that resident's care during his/her period of absence. If a resident has already taken 60 days of covered therapeutic leave at another adult care home or nursing facility, you may not require the resident, family members, or others to pay for therapeutic leave days not covered by Medicaid.